Pre-Employment Medical Questionnaire

If you do not understand a question or need assistance to complete this form, **PLEASE ASK.**

SURNAME:_____:Telephone:_____

Given Names:_____ :D.O.B._____

Address:_____

Details of your usual doctor and treating medical specialist.

Current Medical Practitioner/Family Doctor
Clinic Name and Address _____ _____ Telephone_____Doctor_____

Our organization has a duty of care to provide and maintain a safe working environment so far as reasonably practical and to ensure employees are not exposed to hazards.

Your completion of this form allows us to obtain relevant information so we can ensure, as much as possible, that you area suitable physical and medical match to the role for which you are applying and can carry out the role without the risk of harm to yourself or others.

Please ensure you have read the accompanying physical requirements form before proceeding

If you have difficulties with any of the questions in this form please discuss them with your treating doctor

All details provided on this form are treated as strictly confidential

Do you give permission for your current or previous doctor's to provide further details of your medical history if required:

YES ☐ NO ☐

Please complete the following questionnaire, If you have any questions or do not understand the question, please ASK!

OCCUPATIONAL HISTORY

In your employment have you ever been exposed to any of the following hazards?

☐ Noise, above 85 dB(A) ☐ Chemicals ☐ Skin Irritants ☐ Asbestos

☐ Dust ☐ Toxic metals ☐Ionizing Radiation ☐ Other environmental hazards

*(Details)*_____

If you were exposed to these hazards did you wear, or were you provided with, personal protective equipment? No ☐ Yes ☐

Specify: _____

Did you use it? Yes ☐ No ☐

If No, why not?:_____

PAST AND PRESENT MEDICAL INFORMATION

How would you describe your general health most of the time?

☐ Excellent ☐ Very good ☐ Usually good ☐ Just OK ☐ Sometimes not so good

Have you had any significant illness, admission to hospital or surgical procedure performed in the last five (5) years? (Excluding normal pregnancy and delivery) No ☐ Yes ☐

*Specify:*_____

Are you currently being treated by a doctor for any physical or psychological condition?

No ☐ Yes ☐

Specify: _____

Are you currently taking any prescribed medication ? No ☐ Yes ☐

Specify: _____

Do you have any known allergies? No ☐ Yes ☐

*Specify:*_____

Have you ever sustained an injury in a vehicle accident or sporting incident to the extent that you required medical attention ? No ☐ Yes ☐

Specify: _____

Have you ever suffered an injury, illness or disorder of the mind that resulted in a Workers

Compensation claim? No ☐ Yes ☐

If yes please specify what injury, illness or disorder of the mind, when this occurred and the current status of the condition: _____

_____

_____

Do you consent to allow the company to request your compensation claims history from workcover if required? No ☐ Yes ☐

Have you ever had, or been told that you have, any of the following:
*(Details include **year & current or resolved)***

CONDITION	YES	NO	Details
Dermatitis, eczema, psoriasis, paronychia or			
other skin disease?			
Any unusual lump or swelling on your body?			
Any change to any mole or freckle?			
Arthritis, back injury or bone fracture?			
Back pain, or sciatica?			
Shoulder, elbow or wrist problems?			
Hip, knee or ankle problems?			
Neck problems?			
Muscular sprain or strain? Hernia?			
Nervous disorder, anxiety or depression ?			
Frequent or migraine headaches ?			
Head injury that resulted in loss of consciousness ?			
Blackouts or fainting attacks ?			
Epilepsy, fits or seizures ?			
Have you been exposed to loud noises, e.g. machinery, guns or motor sport ?			
Loss of hearing or ringing in ears?			
Recurrent earache or discharging ears?			
Injuries or diseases of the eyes?			
Need to wear glasses or contact lenses?			
If yes when were your eyes last tested?			
Any other disorder of the nervous system?			
Thyroid or other glandular disease ?			
Diabetes ?			
High or low blood pressure ?			
Heart problems ?			
Varicose veins ?			
Rheumatic fever ?			
Palpitations or irregular heart beat ?			
Chest pain ?			
Pains in legs when walking or climbing stairs?			

Signature of applicant:_____

Life Style

What do you do for relaxation ? eg. Hobbies, sports etc., _____

_____

Do you engage in regular exercise ? No ☐ Yes ☐

Specify: _____

Have you ever smoked cigarettes, cigars or a pipe regularly ? No ☐ Yes ☐

If yes, do you still smoke ? No ☐ Yes ☐

If yes, how many per day ? _____

Do you drink alcohol? No ☐ Yes ☐

If yes, how many drinks per week ? _____

Are there any additional comments you would like to make about your health?

_____

_____

DECLARATION

I hereby declare that:-

- I understand that, if employed, the information I have provided above will be retained on my employee file and that the employer reserves the right to access and use the information in the event of an accident, injury, sickness or claim for workers compensation or for any other reasonable purpose, if so required by law.
- I consent to Wadmin Pty Ltd and or its representative, obtaining or exchanging further medical information from my treating doctor or other health practitioners, if required for the purpose of the assessment.
- My answers relating to my medical and employment history are true and complete.
- I acknowledge and accept as a condition of my employment that if any of the information supplied by me in this medical questionnaire is found to be incorrect, incomplete or misleading, I will be liable to instant dismissal without prejudice.
- I have read and understood the conditions on this form.
- Information provided is confidential and remains the property of Wadmin Pty Ltd.

_____ _____

Name of Applicant Signature of Applicant

Date:_____

_____ _____

Name of Witness (for Wadmin Pty Ltd) Signature of Witness